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ABSTRACT

This report presents preliminary findings based on the first full year of the Child and Family Resource Program (CFRP) evaluation, begun in the fall of 1978. The analyses described in this report are intended to provide answers to four major questions: (1) What is the nature of the CFRP and how do programs vary from site to site? (2) To what extent have the CFRP components (infant/toddler, Head Start, and preschool/school linkage) been implemented to date? (3) What is the process of individualizing services to meet family needs and developing action plans for services to be obtained through CFRP? and (4) Is there evidence that CFRP's have had an impact on families after 6 months of participation in comparison to a group of families not enrolled in CFRP? Following the first chapter's introductory overview of the CFRP objectives and evaluation, chapter 2 addresses the first two questions, while chapter 3 offers comment on the remaining two questions. The fourth and concluding chapter provides a discussion of future study issues and preliminary plans for the CFRP evaluation's third phase. (MP)

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EVALUATION OF THE CHILD AND FAMILY RESOURCE PROGRAM (CFRP)

Phase II Executive Summary

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Chapter 1

INTRODUCTION

In 1973, the Administration for Children, Youth and Families (formerly the Office of Child Development) initiated the Child and Family Resource Program (CFRP) as part of the Head Start Improvement and Innovation planning effort. CFRP was funded as a demonstration program with the intent of developing models for providing services to low-income families with young children--models which could be adapted by different communities serving different populations. There are eleven CFR programs across the country, one in each of the ten HEW regions and one representing the Indian and Migrant Division. Each program receives approximately $130,000 per year to serve a minimum of 80 families.

CFRP is a family-oriented child development program which provides support services crucial for the sustained healthy growth and development of families who have children from the prenatal period through age eight. It promotes child development and meets children's needs by working through the family as a unit and provides continuity in serving children during the major stages of their early development. This is accomplished through three program components:

- an infant-toddler component serving parents and their children in the prenatal-through-three age range;
- Head Start for families with three- to five-year-olds; and
- a preschool-school linkage component to ensure smooth transition from preschool into the early elementary school grades.

Another distinctive feature of CFRP is its emphasis on a comprehensive assessment of each family's strengths and needs and the development with the family of an individualized plan for services to be obtained through CFRP. Families enrolled in CFRP receive the same comprehensive services that are offered by Head Start and additional services tailored to the needs of each family. At the same time, CFRP works to reduce fragmentation and gaps in the delivery of services by existing community programs and agencies.

The CFRP Evaluation

In October 1977, the Administration for Children, Youth and Families funded a longitudinal evaluation to determine the effectiveness of the Child and Family Resource Program. The evaluation is designed to address two major policy questions:

- What should be the nature and extent of services provided to families to enhance their children's development? What processes are most effective in providing such services?

- What should be the nature and extent of the continuity of services delivered to children? For how long and through what processes should such continuity of services be provided?

The Phase II Report, which is summarized here, presents preliminary findings based on the first full year of the evaluation, which was implemented in fall 1978. The analyses described in this report are intended to provide answers to four major questions:

- What is the nature of the CFR program and how do programs vary from site to site?

- To what extent have the three CFR program components been implemented to date?

- What is the process of individualizing services to meet family needs and developing action plans for services to be obtained through CFRP with the family?

- Is there evidence that CFR programs have had an impact on families after six months of participation compared to a group of families not enrolled in CFRP?

The first two questions are addressed in Chapter 2; information about program process, treatment, and preliminary impact on families is the focus of Chapter 3. The concluding chapter provides a discussion of future study issues and preliminary plans for the CFRP evaluation's third phase.

The CFRP evaluation incorporates three distinct but interrelated components: a program study, an impact study, and an in-depth study. The three studies are complementary ways of viewing the effects and effectiveness of CFRP. Only six of the CFR programs have been involved in the evaluation to date: Jackson, Michigan; Las Vegas, Nevada; New Haven, Connecticut; Oklahoma City, Oklahoma; St. Petersburg, Florida; and Salem, Oregon. These sites were not randomly selected; they were chosen based on their ability to recruit the requisite number of families for the impact study sample.

The program study is designed for the purpose of developing a comprehensive picture of the operations of CFR programs. Information collected during site visits and in interviews with program staff is used to develop profiles of program implementation and to establish a descriptive context for the statistical and analytic findings of other components of the study.

The impact study is designed to determine the effects of CFRP services on families by means of comparing CFRP families with a group not enrolled in the program. Families with a child less than one year old at time of entry into the evaluation, in fall 1978, were randomly assigned either to CFRP treatment or to a control/comparison group. The families will be followed until the focal child has completed at least one year of public school (1985). Impact study data were obtained at three time points: fall 1978 (baseline), spring 1979 (six months after the families entered the evaluation), and fall/winter 1979, when the development of focal children was assessed using the Bayley Scales of Infant Development. The results of child development assessment analyses will be the focus of the next report, to be submitted to the Administration for Children, Youth and Families in late spring 1980. Data were gathered by on-site teams consisting of a research coordinator and local interviewers.

The in-depth study focuses on the CFRP families who participate in the impact study at the six sites. This study is designed to explore relationships among characteristics of families and staff, interactions between staff and families, services provided, and program impact. Data were collected in both fall 1978 and spring 1979 through interviews with staff and families. In addition, ongoing collection systems were maintained for data concerning family participation in the program, family goals, and referrals for services.

Previous evaluation reports. Further information on the CFRP evaluation can be found in three reports prepared for the Administration for Children, Youth and Families by Abt Associates Inc. They are:

- CFRP Evaluation Design Report, March 19, 1979

- CFRP Evaluation Report No. 2, March 19, 1979, concerning study implementation and preliminary analyses of baseline data

- CFRP Evaluation Phase II Report:
  - Volume I: Research Report and Preliminary Six-Month Findings, March 1980
  - Volume II: Program Study Report, March 1980

Chapter 2

THE CFR PROGRAM

Information presented in this chapter provides a broad description of the operations of the six CFR programs* that were selected for the CFRP evaluation. Two questions are addressed in this chapter based on data collected for the program study:

- What is the nature of the CFR program and how do programs vary from site to site?
- To what extent have the three CFR program components--infant-toddler, Head Start, and preschool-school linkage--been implemented to date?

A third mandate of the evaluation was the development of program models that could be replicated in other communities. To date, the identification of CFRP models has met with only limited success because programs are few in number and disparate in nature, as is discussed below.

What is CFRP's relationship to Head Start?

CFRP and Head Start are closely related; the degree to which the two programs are integrated varies, however, from site to site. In some sites, CFRP is the umbrella agency of which Head Start is a part. In other communities, the two programs operate relatively independent from each other. A third model is CFRP as part of a Head Start umbrella agency, with CFRP "tacked on" as another program component.

*The six sites are: Jackson, Michigan; Las Vegas, Nevada; New Haven, Connecticut; Oklahoma City, Oklahoma; St. Petersburg, Florida; and Salem, Oregon.

How many families are served by CFRP?

Demand for CFRP typically exceeds supply; most programs maintain waiting lists of families who wish to enroll in CFRP. Family enrollment is considerably higher than the 80 to 100 mandated in program guidelines. In fall 1978, enrollment averaged 128 families, ranging from the mid-eighties in Oklahoma City and New Haven to over 200 in Jackson.* By spring 1979, enrollment had increased by 15 percent, to an average of 147 families per site. In addition to families enrolled in CFRP, most programs provide crisis intervention services to non-enrolled families. This kind of service is extensive in Las Vegas and virtually nonexistent in Salem, where non-enrolled families are referred to other community agencies which program staff believe are better equipped to provide this type of service.

What are the characteristics of CFRP families?

Two-thirds of the families served by the six CFR programs represent ethnic minority groups--56 percent black, 6 percent Hispanic, 2 percent Native American, and 3 percent of biracial background. The Jackson and Salem programs serve predominantly white populations. The few Hispanic families are mostly in the Las Vegas and New Haven programs.

At entry into CFRP, the mothers' mean age was 27 years. A large proportion of the mothers were between 21 and 25 when they enrolled in CFRP; about 12 percent were under 20, and 5 percent were 18 or under. Las Vegas has by far the

*Not all of the families at all sites are funded 100 percent through the CFRP program; some are paid for by other program monies.

largest proportion of teenage mothers; the youngest mother was 15. Over half of the mothers have completed high school; the majority are unemployed, except in St. Petersburg.

Most CFRP families entered the program at a time when they had children of both infant-toddler and Head Start age, although this differed among sites. In Jackson, for example, 92 percent of the families had a child of Head Start age, whereas only 40 percent had a child of infant-toddler age. Conversely, in Las Vegas 52 percent had a child of Head Start age, compared with 81 percent infant-toddler. This could indicate that the Head Start and infant-toddler components of CFRP are being emphasized to different degrees at the six sites.

Over a third of the mothers are married or "informally married"; 24 percent have never been married. CFRP household size ranges from 2 to 14 and averages 4 members. Most of the families have incomes below $6,000 per year, or a per capita income of approximately $1,500. Two-thirds of the families receive public assistance from welfare or AFDC.

How are CFR programs staffed and organized?

CFR programs typically have from 10 to 20 staff members. Jackson reports by far the largest staff; this is not only the result of high family enrollment in CFRP, but also of an almost total integration of Head Start and CFRP. Jackson staff find it difficult to distinguish between the two programs. Las Vegas and Oklahoma City have the smallest staffs. About half of the CFRP staff work directly with families; the proportion is higher, however, in programs with only minimal staff. The remainder of the CFRP staff consists of program administrators and specialists.

There are a number of differences in the way the six CFR programs are organized. At three of the sites, there is one person who is responsible for working with families, usually a family advocate or home visitor. The other sites--Jackson, New Haven, and Salem--employ a team approach to providing services to families. One of the main advantages of this team approach is that it facilitates coordination of services and problem-solving, and reduces the potential of staff burn-out. Sites also differ in the types of services they provide directly through program staff or contract out. In Salem, for example, the health coordinator is a public health nurse, contracted by the program for 80 percent of her time; the education director is 50 percent Head Start and 50 percent Board of Education (as early childhood coordinator for Salem Public Schools). In St. Petersburg, the family life study coordinator is a contracted counselor who leads parent meetings; the home visitor supervisor is also contracted through another agency. In Oklahoma City, training is done by contracted personnel, and for a time coordination of the infant-toddler program was also contracted out.

What are the characteristics of CFRP staff?

The ethnic makeup of the CFRP staff in most cases corresponds roughly to that of the families enrolled in the program. At four of the six sites, the great majority of the staff are black. Staff age ranges from 18 to 76; the mean age for staff is in the mid-thirties. The great majority of staff are married or have been married. Most have

children of their own, and more than half have children at home. About a third of the staff have had children in Head Start, with a very large proportion in New Haven (78%) and a small proportion in Salem (7%).

CFRP staff have had between 14 and 15 years of formal education on the average. About 40 percent have bachelor's degrees, and about 13 percent have master's degrees. A larger proportion of the staff have taken non-degree education programs or attended workshops or short courses related to their work. The most popular disciplines include social work and sociology, education, mental health and psychology, and child development.

Staff members have worked in CFRP an average of 2.2 years. Most are full-time workers in the program and work year-round. This is not the case in New Haven and Salem, however, where substantial proportions of the staff work during the school year only. About two-thirds of the staff are involved with the infant-toddler component of the program. About 80 percent work in Head Start, and about half in the preschool-school linkage component. Only about one-third have responsibility for running parent groups or teaching adult classes.

What services are provided by CFRP and through what processes?

CFRP services are offered within the context of the three major program components--the infant-toddler component, Head Start, and preschool-school linkage. Each is intended to serve families with children in a specific age group; all three taken together are intended to provide continuity--especially developmental and educational continuity--across the period of a child's life from before birth to the primary grades in school.

To ensure that CFRP services are individualized to the maximum extent possible and that specific family needs are met, programs have established formal processes for needs assessment. Parents play a major role in determining family needs, setting goals, and developing a plan of action to achieve those goals. Reassessment is scheduled periodically at all sites.

CFRP family workers report an average caseload of 22 families; caseloads are much smaller in New Haven (11) and somewhat smaller in Oklahoma City (17). The number of families that a family advocate or home visitor works with depends, however, on the ages of the children in the family. In Salem, for example, caseloads are considerably smaller for families with infants or toddlers (13 to 16) and larger for families with children in Head Start, since they participate in home visits less frequently. Staff contact occurs mostly in the form of home visits and parent meetings. Most family workers provide some direct services to families or refer families to other agencies for a variety of services. Some programs emphasize referrals more than others.

The infant-toddler component of CFRP is intended to provide developmental stimulation for the young child and, on the parent's part, to improve parenting skills and the quality of parent-child interactions. Infant-toddler center sessions tend to focus on parent and child separately--staff work with the children while parents participate in discussions on topics related to child development and parenting. By contrast, in home visits the focus is very much on the parent <u>with</u> the child. In several programs, some instrument is employed to assess the child's development on a regular basis, and the results of these assessments are shared with the parent.

The Head Start component within CFRP is essentially the same as any Head Start program, except that the broader spectrum of CFRP services is provided to the family. This includes needs assessment, goal-setting, and the development of an individualized plan for services to be provided through CFRP.

The preschool-school linkage component of CFRP is designed to ease the transition from Head Start to elementary school for children, their parents, and school personnel. This is the least clearly defined and well-developed of the three major CFRP components. Some transitional services are provided, but they often appear to be incidental by-products of Head Start. Services offered include orientation of children, their parents, and school personnel; liaison between parents and schools; troubleshooting in response to requests from parents or school personnel; and tutoring of children.

All six programs emphasize parent involvement. Among other things, this takes the form of parents serving on the policy council, or working in the program as volunteers or paid employees. The New Haven CFRP particularly emphasizes the latter, while Salem staff do not encourage it. All CFRPs offer activities especially for parents, partly in an attempt to increase participation in child-oriented aspects of the program. All have experienced difficulty maintaining parent participation at an optimum level. Some of the programs have experimented with tangible incentives as a means of encouraging participation. At all six sites, opportunities are offered for providing feedback on program activities, in an effort to ascertain parents' interests and to be responsive to their perceived needs.

Chapter 3

CFRP TREATMENT AND PRELIMINARY SIX-MONTH PROGRAM IMPACT

In this chapter, we examine CFRP treatment and the processes used to deliver services to families, as well as preliminary program impact after families had been in the program for six months. Findings reported here concern families selected for participation in the in-depth and impact studies. Their characteristics are somewhat different from those of the families described in Chapter 2; this is largely the result of recruiting guidelines which required the enrollment of families with children under one year of age in fall 1978. Mothers in the study tend to be younger, with a significantly higher proportion under 20 years of age. In addition, over half of the children who are the focus of the study are first-born. It should be noted that characteristics of study families are not the same at all six sites.

The chapter is organized into two sections. Section 3.1 examines CFRP treatment. Among the questions addressed are the extent to which services are individualized to meet family needs; parent involvement in the development of action plans and the setting of goals; family participation in program activities; and services provided to families. Section 3.2 focuses on preliminary program impact on families after they have been in the program for six months. It examines impact in four outcome domains which CFRP is expected to influence--family circumstances, health, parent-child interaction, and capacity for independence. CFRP impact on child development will be assessed in subsequent reports.

3.1 CFRP Treatment

To what extent does CFRP focus on the family rather than the child?

There is convincing evidence that CFRP places major emphasis on the family. It works through the family as a unit to meet children's needs and to promote their total development. There is extensive parent involvement in the needs assessment process, the development of action plans for services to be obtained through CFRP, and the setting of goals for the family. Of the needs identified, most concerned the family.

What types of needs do CFRP families have?

At the time families entered the CFR program, they identified an average of 2.8 out of a possible 6 different types of needs. Among the most frequently reported needs or problem areas were employment, family problems (including lack of childrearing experience), housing, and insufficient income. The problems and needs of families appear to be very practical ones, most of them not directly related to the development of the child.

In addition to needs and problem areas, family workers identified strengths of the family. Strengths together with family needs form the basis for developing an individualized family action plan for services to be received through CFRP. Family workers gave particularly positive reports on the status of the focal child and on the mother-child relationship.

What is the focus of family goals?

In the first reporting period (January-March), families had an average of 4.9 goals. This ranged from 7.3 goals per family in Salem to less than one per family in New Haven. In the second reporting period (April-June), the mean number of goals per family was somewhat lower (3.4).

Family goals mirror problems that family workers and parents identified in the needs assessment process. The most common goals concern the health of the child or other members of the family, adult education, housing, employment, and parenting skills. The types of goals that were set, however, were not of the same nature at all six sites. For example, Las Vegas places more emphasis on education goals; in Jackson and Salem, the focus is more on the development of parenting skills and improving personal and interpersonal skills. The vast majority of the goals concerned parents or the parent and child together. This again reflects the fact that CFRP is a family-oriented program.

The great majority of the families had both one-time and ongoing goals. One-time goals refer to things that could be accomplished by one visit to an agency or doctor; ongoing goals refer to changes over time, such as in the area of parent-child interaction.

To what extent are services individualized to meet specific family needs?

Based on staff reports and records concerning needs and goals, we can conclude that services are highly individualized and tailored to meet specific family needs. Family workers indicate that they emphasize different

content areas and services in dealing with different families. Major emphases have included improving parenting, child development, providing parent services, personal growth experiences for the parent, educational counseling, arranging child services, increasing program participation, job training, and family management.

How frequently are families in contact with the program?

The most common type of program contact with families is through periodic home visits and group meetings at the center. In most of the six programs, home visits are reported to take place twice a month, with group sessions occurring on alternate weeks. Group sessions take the form of infant-toddler or parent education sessions, parent or policy council meetings, and social activities. Actual contact with study families since they entered the program, however, was a good deal less. It occurred on the average about twice a month, mostly through home visits by a family advocate, home visitor, or occasionally a specialist from the CFR program. Home visit contact was higher in the Jackson and Salem programs than at the other four sites.

Participation in group sessions at the CFR center was minimal during the first nine months after the families entered the program. Families attended an average of one session every three months.

What types of services do families receive?

In addition to direct services provided in home visits and group sessions, families are referred an average of once every three months. The mean number of referrals per family was considerably higher, however, in Salem,

St. Petersburg, and Las Vegas. The largest proportion of referrals were for health-related needs. Other frequently occuring referral types were economic needs of the family, employment, and housing. Parents were the most likely recipients of referral services.

3.2 Six-Month Program Impact

In order to determine whether CFRP has had an impact on families after participating in the program for six months, CFRP families were compared on four outcome domains with a group of families not enrolled in the program. These domains are closely linked to CFRP objectives and therefore are likely to be affected by family participation in CFRP. The domains are family circumstances, health, parent-child interaction, and capacity for independence. In addition, staff reports were examined to determine what progress families had made toward attainment of goals since they entered the program.

Is there evidence of six-month program impact?

There is little evidence yet that CFRP has had a positive impact on the families in the first six months of program participation. It is reasonable to assume that families had been in the program for too short a period of time for such impact to become apparent. It should be noted that a number of the problems the CFRP families face are long-term in nature; in such cases it may not be reasonable to expect positive impact after only six months. For example, it is unlikely that family circumstances--in terms of such things as family income or reliance on public assistance programs--would change in six months. Similarly, changes in parenting skills or the amount of positive

interaction between mother and child may not become apparent until the family has been involved in the program for a longer period of time. Results of a pilot study concerning parent-child interaction conducted at two sites (Oklahoma City and Salem) provide preliminary evidence of program impact in this area. CFRP mothers had more frequent interactions with their children than was the case for mothers in the control/comparison group, though program impact on parent-child interaction differed somewhat at the two sites.

What progress do staff report?

After six months in the program, family workers noted a number of signs of progress in families. They most frequently reported personal growth, taking more responsibility for own needs, making progress toward goals, and taking more responsibility for the child's needs. Almost half of the families had completed one or more goals during the first six months; 41 percent were reported to have made some progress toward attaining one or more additional goals. In some cases, a goal was dropped or changed in focus.

The other kind of progress on which family workers commented was family independence from the program. Most families are seen as independent or very independent of CFRP; for about a quarter of the families, independence varies; 16 percent of the families are reported to be dependent or very dependent on the program. Judgments about independence were based on the fact that the parent is a self-sufficient, capable person, that the parent seeks program help only for specific needs, that the parent feels no need for the program, or that the family relies on other services.

There is something of a paradox here, in that a parent's feeling no need for CFRP and relying on other services is seen as indicative of independence--and therefore, presumably, of progress. Yet a major frustration faced by CFRP staff is a lack of program participation on the part of families. This paradox is to some degree inherent in the CFRP philosophy. Family independence is supposed to be encouraged, yet so is family participation in the program. No doubt, it is often difficult in a specific case to judge whether chronic nonparticipation is a positive sign of family independence or a negative sign of parental disinterest.

What views do families have of the CFR program?

After six months, parents hold a generally positive view of their participation in the program. About two-thirds of the families are satisfied with the amount of time demanded by program activities; about one-quarter would like to spend more time in the program. In terms of program activities, most parents indicated that CFRP finds activities that are right for them and their children, and that they are pleased with center-based activities. Half of the parents also indicated satisfaction with how much "say" they have in what is done in home visits. On the other hand, some parents said they would like to be more involved in decisions regarding how the program is run.

There were few negative reports about the program; however, some parents did indicate having difficulty getting to program activities, either because of transportation problems or because of the hours at which meetings were held. Others mentioned changes they would like to see in the program. These were mostly in the area of providing more

child care, although a few concerned employment counseling and satisfying immediate needs such as health care, housing assistance, or help with adult education. The majority of families feel that CFRP has not had any influence on their interactions with other community agencies. Among those who think it has had an influence, most see other agencies as being more cooperative now.

Chapter 4

RECOMMENDATIONS AND FUTURE STUDY ISSUES

At the conclusion of the first year of the CFRP evaluation, a careful review was conducted of study variables, instruments for data collection, and overall design. The purpose of this review was to use what was learned in the first year in looking for ways to strengthen the evaluation. These and related issues, including preliminary plans for the next phase of the study, are the focus of this concluding chapter.

Is it realistic to expect program impact on all five outcome domains?

Because the CFRP treatment is of a highly individualized nature designed to meet specific family needs, it is not likely that all families will benefit from the program in the same way. As a result, it is probably not realistic to expect the same kinds of program impact on all outcome domains. These domains--family circumstances, health, child development, parent-child interaction, and capacity for independence--fall essentially into two categories: (1) those that may be viewed as central to the overall objectives of CFRP; and (2) those which relate to specific family needs and goals. These categories are discussed in more detail below.

One of CFRP's primary goals is to promote the development of children and to meet their needs by working through the family as a unit. This is accomplished through periodic home visits and center sessions which are aimed at improving parenting skills and interactions between parent

and child. Because of this underlying CFRP philosophy, all families are expected to benefit from the program over time in the areas of child development and parent-child interactions. The other three domains--family circumstances, health, and capacity for independence--are of a different nature because they are directly related to family needs. For example, one would not expect change in mother's employment status as a program impact except in families that indicated a need or desire for such changes. Program impact in these three domains can only be detected by linking outcomes to needs. Such linkages were not feasible in the past year because data concerning family needs were available only for the CFRP treatment group. In the study's next phase, an attempt will be made to obtain comparable data from the control/comparison group. Program impact analyses will necessarily be more descriptive than statistical as sample sizes will be small.

Have we effectively assessed CFRP processes and treatment?

Much was learned about the processes used to deliver program services to families and about CFRP treatment in the study's first year. Our knowledge of CFRP can be broadened considerably, however. We must get a better understanding of how CFRP functions as a family support program in the community and its effectiveness in helping families. What kinds of support are provided, in what ways, and by whom? Is CFRP more effective as a family support program for certain groups of families, such as teenage mothers, working parents, and so on? These aspects of the program are difficult to assess through brief staff and family interviews or program records. It is even more problematic to try to relate processes and treatment to specific outcome domains, due to the individualized nature

of CFRP and family needs. Sample sizes are so small that they may obscure any meaningful relationships. More in-depth interviews may be required to capture the "essence" of CFRP and to provide new insights into program impact on families.

What will be the focus of the next phase of the evaluation?

In the next phase we plan to collect data for all three components of the CFRP evaluation. Data collection will take place in spring (1980) rather than in both spring and fall.

The program study will focus on changes in program operations in the past year, and the status of the three program components--infant-toddler, Head Start, and preschool-school linkage. In addition, we will investigate the issue of program contact with families and family participation in program activities. As noted in the previous chapter, contact was considerably lower than anticipated. This may be due simply to underreporting by staff of program contact, or it may have other causes.

A considerable portion of the program study site visits will focus on CFRP linkages with social service agencies in the community. Through interviews with CFRP staff and agency representatives, we will attempt to determine if and in what ways CFRP has had an impact on the availability and quality of services for low-income families. Among the questions to be addressed are: Are services more accessible to families as a result of CFRP? Is there evidence that community agencies are more sensitive and responsive to the needs of low-income families? Do families in CFRP receive services of better quality due to referrals than families not in CFRP? What kinds of changes have taken

place in the agency since CFRP became operational and how did CFRP influence these? In addition, we will examine more closely the types of direct services that are provided by CFRP staff. Are these offered because the services are scarce or non-existent in the community, or are there other reasons? Has CFRP tried to establish working relationships with agencies and, if so, why are they not viable? Is CFRP in any way in direct competition with other agencies in the community or are services duplicated unnecessarily?

The impact study will examine four of the five outcome domains: family circumstances, health, parent-child interaction, and capacity for independence. The development of the focal children will not be directly assessed again until they enter Head Start next year. Instead of child assessments, we plan to expand the parent-child observation study to more sites and additional families per site.

The in-depth study will remain largely unchanged in scope. Data concerning family participation, goals, and referrals will continue to be obtained on an ongoing basis. In addition, we plan to conduct interviews with staff about families in the impact study to get their views on progress toward attaining goals and changes in the family that have occurred over time. Families also will be interviewed about their participation in the program.

In the next phase of the study, we will develop a plan for conducting a series of in-depth interviews that would broaden our understanding of how CFRP works with families and functions as a family support program. These interviews would also increase our knowledge about types of impact the program may have which are not evident from the brief interviews that are conducted for the impact study.

The in-depth interviews would involve families, the CFRP staff who work with them, as well as agencies in the community that provide services to the families. The addition of these interviews will strengthen the CFRP evaluation considerably.